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THE HAMPDEN HIPPOCRAT

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IN THIS ISSUE

Report of the Public Health Committee	5
HDMS President's Message	6
Personal Finances	7
Baystate Medical Center	8
Increased Application of the Antiturst Laws to Physicians	10
Annual Meeting of the Hampden District Medical Society	12
Report by Philip Stoddard, M.D.	13
Report by Ms. Judith Schumacher	14
Obesity Is All In The Mind	15
The Cynic Bulletin	18
Excerpts of MMS Executive Briefs	19
Committee Activities	22
Welcome New Members	23

On our cover is Baystate Medical Center in Springfield, Massachusetts. See related article on page 8 in this issue.

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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Report of the Public Health Committee

The Committee would like to call attention to the continuing and expanding availability of the Chemical Dependency Services of Providence Hospital, Holyoke. In addition to its Elm Street Center, Holyoke Office, it recently opened an Office and Methadone Clinic in the Springfield Health Department Building, at 1414 State St., despite considerable local apprehension and opposition. (To be sure, because of the Clinic in the Building, our own Medical Society no longer is allowed access to the front door!)

We recently listened to the Program's former Director, Mr. Edward King, who promptly resigned his post thereafter. Mrs. Deborah Bach, now Acting Program Director, supplied the following current information.

In 1988, the two Clinics, in Holyoke and Springfield, enrolled 356-patients. Their average age was 33 years. 63% were males and 37% females. 58% were white, 29% Hispanic, and 13% black. The services provided include, principally, Methadone Maintenance—short-term, for 6-18 months; and extended care, for more than 18 months. One-third of current patients, or 108, were expected to receive services for at least 6 months, and two-thirds, or 248, for at least 12 months. Other services offered by the Clinic are: Aids education and prevention; neonatal addiction; chronic pain; and PTSD. Despite problems, the Holyoke Office lists a Staff of 12 members, and Springfield 11. Enrollment procedures usually consist of: waiting list application; intake assessment; urinalysis (for drugs); lab work; physical examination; and case review. Sources of referral include: self; human service agency; health-care professionals; the courts; probation; and parole.

For most of us, even as physicians, those facts are merely of passing interest or just plain curiosity, before they are forgotten. In other words, who cares? When we consider the magnitude and complexity of the problem, that should not be the case. Besides, it is not new—we were actually there long ago.

With alcohol, for example, after it was distilled and, therefore, concentrated, in the 19th century. The drug moved from the sick-room to recreational use, as *aqua vitae*, in the 13th century. At first, its use, especially to the point of drunkenness, was considered a matter of individual choice or voluntary. In the 19th century, however, the medical profession, in America and England declared such excessive use to be a disease, calling for treatment as well as prevention. The term, "chronic alcoholism", was introduced 140 years ago, in 1849.

Or later, with morphine, which was extracted from natural opium in 1817 and then injected when the hypodermic syringe came along in 1859. Laudanum, the alcoholic tincture of opium, preceded morphine in widespread medicinal use. Thus, it was the concentrated forms of both alcohol and opium, followed by their extensive use in medical practice, that eventually set the stage for the development of the disease concept of addiction.

Jellinek, with his Yale School of Alcohol Studies, extended the concept of alcoholism in this century. Alcoholics Anonymous (AA) was founded 54 years ago, in 1935—the same year the U.S. Public Health Service at Lexington, KY opened for the treatment of narcotic addiction.

It should be noted, also, that the Harrison Act of 1914 made opiate addiction in the U.S.A. a crime rather than just a disease. Again the XVIIIth Constitutional Amendment in 1919 made the manufacture, sale, or transportation of alcohol illegal. It was a total social failure and had to be repealed 14 years later, in 1933.

Not to mention nicotine and tobacco. After all the years of use, the first medical reports on their dangers are only 40 years old, in the late 1940's. The first Surgeon General's Report on the health hazards of smoking was published 25 years ago, in 1964—but only very recently, within the past 1-2 years, Surgeon General Koop's public affirmation that nicotine and tobacco were addicting!

Finally, Aids, discovered in 1984 and identified with iv-drug use (and homosexual behavior), is forcing more attention to the control of narcotic drugs in this country. Reverend Jesse Jackson is attempting to do the same. After those observations, who knows what is next to come? ■

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HDMS President's Message

Nancy L. Weiss, M.D., President

Mustafa Adham, my mentor and a surgeon many of you will remember, told me he always sat down on New Year's Day and wrote out his goals for the next year. I took his words to heart and have practiced that for many years. As I start my new year as President of the Hampden District Medical Society, my goals all concern improving relationships: physicians with their patients, physicians with each other and physicians with the Hampden District Medical Society.

Until recently, I did not realize how much our local society has to offer us as individual physicians. Our executive secretary, Carol Nystrom, does an excellent job of answering questions, knowing such things as where risk management courses are offered or which surgeons take Medicaid. Our Mediation Committee, chaired by Dr. Ken Frankel, has helped many physicians resolve difficulties with patients and I am sure averted many lawsuits. Our travel service, INTRAV provides well run and varied tours around the world. I hope you will use the resources your dues provide.

Our goals with patients must go beyond help for the current complaint. Patients still think highly of their own personal physician yet often distrust the institution of medicine and doctors in general. This comes from the mass of information bombarding the public. Much of it is confusing and conflicting, contributing to the distrust. We must speak out and use the influence of the mass media to affect patients' understanding and attitudes. Toward this goal of building a better coalition with our patients, the public relations committee has started members writing newspaper articles, being interviewed on radio and local television and preparing an up to date speakers bureau. The more we can build this coalition with our patients using positive community relations, the more support we will have as government and insurance groups try to take over the practice of medicine.

Finally, my most important goal is that the Hampden District Medical Society should be much more a forum of support for each other. Too often others outside of medicine use the divide and conquer approach. The Hsaio study is a prime example. This study has pitted the procedure oriented physicians against those who are not, by using "cognitive" as the opposite in meaning to procedure, clearly insulting to surgeons and very divisive in effect. Another prominent division is created by a physician's source of income; fee for service versus salary. This has tended to seperate the private practice doctors from full time academic and prepaid health plan doctors. Yet surely our problems of access to care, physician shortage, malpractice litigation, increasing regulation and loss of professional autonomy should draw us closer together, not further apart. We have intellegience, eduation and a proven willingness to work, all going for us. Let's use them to make our profession what we idealized it would be, one we can again enjoy and encourage our children to enter. ■

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Investment Management

Most investors do not have the time, ability, or interest to carry out the day-to-day management of their assets. This is true to individuals, charitable organizations, and corporations, both large and small. Because of this, investment management has grown to the point where it controls an estimated 60% of all stocks and bonds in the United States.

Investment Management is a trend that has been accelerated by the ever increasing wealth of investors and the growing profusion and complexity of investment alternatives. As a result, non-professionals have rightly come to believe that they are at a disadvantage when trying to invest their own money. For this reason, it might help to examine some specific benefits that investment management offers.

1) *Full-time management.* Full-time managers have better and more current information and are in a position to act quickly.

2) *Improved investment results.* Greater levels of training, experience and available information all act to give investment managers a significant advantage.

3) *Continuity of management.* In cases of individual or organizational disruptions, investment management can provide ongoing supervision and a consistent approach.

4) *Relief from record-keeping headaches.* Particularly helpful to those who are less organized.

5) *Reduced Stress.* Eliminating the burden of investment decisions causes stress levels to decline.

6) *Coordination of investments with goals.* Professionals have much more experience in understanding goals and then translating these into investment decisions. Important here too is that they are much more accustomed to making and carrying out decisions.

With these basics in mind, the following description should be helpful in explaining a little more about St. Germain and the service we provide our clients.

Introduction

As a pioneer in the field of professional money management, St. Germain has long been helping individuals, organizations, and corporations to achieve greater investment returns. Our approach to the investment process has been thoroughly tested and proven to be successful. It is today the same one that has worked so well for our clients for over 60 years. The proof of this can, in part, be measured by the fact that more then 90% of our clients have recommended our service to their friends, relatives, and business associates—showing a level of support of which we are very proud.

Investment Philosophy

Because history has shown that equities produce the greatest overall return and liquidity, investment grade common stocks form the core of each portfolio. Within this high grade universe, we tend to seek out companies that are "temporarily out of favor," have steadily increasing intrinsic values, and are selling at discounts to their real worth.

This approach is also known as low P/E or value investing and has proven its merit many times over the years. Occasionally in the heat of a strong market rise, this method of selecting stocks may seem stodgy or out-of-date. Then, when the inevitable market correction comes, investors always rediscover the benefits of seeking value. In summary, our temporarily out of favor approach allows our clients to participate in growth markets, but also builds in a degree of protection during adverse times. It produces conservative growth without the volatility normally found in common stock investing.

Experience

Our portfolio managers are officers of the firm and average 20 years with St. Germain and over 25 years in the business of investing money for others. We believe this level of experience is necessary in building the type of client relationships that have been our trademark.

In addition, when investing money, there is no substitute for this depth of experience in sorting out important events from not-so-important. In investing it is very easy to become distracted by the many short-term influences that are always present. Experience is the factor that permits these critical distinctions to be made.

Cost Benefits

With over $220 million under management, we are able to provide each account with significant commission discounts—discounts that usually would be available to only the largest funds. This can easily amount to an annual savings of 1% to 2% of the value of each account.

Furthermore, our unique system of investing permits this cost advantage, while allowing us to give each account the individual attention that is needed. This is part of what makes St. Germain different.

Record Keeping

We provide next-day confirmation for each transaction, monthly reports summarizing all cash flows, quarterly account valuations, and a year-end itemized summary for each account. Everything needed for tax and evaluation purposes is sent in a timely and easy-to-read format.

Conclusion

St. Germain then, has a long history of managing money for those seeking conservative growth. The combination of our performance results, experience, trading efficiencies and individual account attention make our service unique within the investment management business. ■

John M. Lewis, CFA Vice President

This "PERSONAL FINANCES" article was solicited from D.J. St. Germain Co., but is not to be viewed as an endorsement.

Baystate Medical Center-"Positive Leadership for Western New England"

This is the third in a continuing series of articles featuring Western Massachusetts Hospitals

As the world of health care has changed, Baystate Medical Center has changed with it. And in the process, the organization, comprising 4500 employees, over 650 medical staff, and expansive programs from primary to tertiary care, has achieved state and national prominence.

Baystate Medical Center has thrived on change. Built on the merger of three proud institutions, Baystate has made steady progress in uniting facilities, systems and people. Today, the North and South Campuses are part of the growing Baystate Health System Network, which includes Franklin Medical Center to the North; a network which provides the organizational and legal structures necessary to move and mold rapidly as the world changes.

The transformation is highly visible. New facilities such as the Centennial Building and the Medical Office Building house state of the art technologies in radiology, laboratories, intensive care units and surgery. The same technology will be evident in a new OB-Newborn facility featuring cluster design LDRP's slated to break ground this Spring and to house one of the nation's twenty largest maternity practices. Older physical plants on the North and South Campus have been gutted and rebuilt. A new 750-space parking garage breaks ground this month to augment the existing 350 space MOB garage. Together, they resolve a nagging parking problem. Inside an expanded Environmental Services Department has the facilities sparkling.

As the facilities have been transformed, new time efficient systems and service oriented programs have evolved. Baystate today is the only Medical Center on the Eastern Seaboard with three separate surgical facilities designed for the special needs of primary secondary, and tertiary surgical patients and their families. A 25,000 square foot Ambulatory Surgery Unit houses the new kidney lithotripter and many laser services. The uniqueness of the surgical facilities has drawn visitors from around the U.S. Surgical capacity has been doubled in just eighteen months and turnover time in the DayStay Ambulatory Surgery unit averages 8 minutes.

Along with new facilities and efficient systems has come a steady and gradual move toward expanded physician resources and subspecialization in areas from shoulder arthroscopy to spine surgery; from pediatric neurology to GYN pelviscopy; from electrophysiology and implantable defibrillators to renal transplants; from specialized gastroenterology testing to interventional radiology; from retinal ophthalmology to child psychiatry.

Growth in nursing resources has been equally dramatic with a decline in vacancies from just under 14% to approximately 5%, which is among the nation's lowest. This has resulted from aggressive recruitment and major redesigns of nursing work schedules, off-hour incentives, clinical ladders, and special attention to nurse/physician relationships. Today, people again recognize Baystate as a center for nursing leadership as evidenced by the highest enrollment ever recorded in our Nursing School at a time when other nursing schools have been forced to close their doors.

In the area of education, Baystate has made rapid progress. Four of our clinical Chairmen now serve on National Residency Review Committees, and research grants this year have topped 2 million. Today, as the Western Campus of Tufts University School of Medicine,

continued

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Baystate is home for 150 Residents from over 60 U.S. Medical Schools. On the undergraduate level, there has been a 15% increase in third-year students and a 50% increase in fourth-year students from 48 medical schools. Why? Because Baystate's staff of hospital-based and community-based physicians provide a superior education, and Baystate's patient population closely mirrors what students will encounter when they begin to practice medicine in communities throughout America.

As health care continues to evolve, Baystate's future will be tied to the strong partnership that has developed between physicians and management. Medical Staff leadership, organizationally restructured two years ago, provides timely input on a biweekly basis. Full-time Chairmen, meeting biweekly as well, chart and direct clinical development. A strong management staff from all regions of the United States, under the direction of BHS President, Michael Daly, and BMC Chief Executive Officer, Clifford Eldredge, today includes three physician Vice Presidents. Finally, Baystate's new computerized Patient Care Information System, which is the model TDS installation in the United States, is being installed under the direction of a practicing physician. Working hand in hand, physicians and management chart our course and shape our future.

Two years ago, upon completion of several notable achievements, including the hospital mergers, the development of Health New England, the construction of the Centennial Building and the MOB, Baystate and its Medical Staff took a deep breath and reaffirmed that the decision to enter medicine was and remains the right decision. This positivity found a forum in the Pride in Medicine project which is entering its third year under the sponsorship of the Massachusetts Medical Society, the Massachusetts Hospital Association, and the Massachusetts Organization of Nurse Executives.

This year, Baystate Medical Center received special recognition at the AMA Leadership Conference for initiating the project because they had recognized a simple truth: that positivity is not public relations. Positivity is performance and productivity; the ability to plan with hope and confidence; and the ability to recruit and retain energized health care professionals who will be responsible for guiding health care safely through this period of great change.

Baystate Medical Center has set its eyes on the future concentrating on education, communication, positivity, and working partnerships with physicians. The health care world is changing, placing special challenges on all of us. By working in concert with physicians, the Baystate intends to create a positive and stable environment for doctors and their patients that will prosper and endure into the future. ■

Michael Magee, M.D.

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Increased Application of the Antitrust Laws to Physicians

This article was written by Francis D. Dibble, Jr. and Laurel H. Brandt, who are partners in the Springfield law office of Bulkley, Richardson and Gelinas.

Physicians are increasingly under antitrust attack. Twenty-four Western Massachusetts obstetrician-gynecologists and their professional corporations have been sued by the Masachusetts Attorney General in a civil case seeking an injuction and substantial civil penalties for allegedly boycotting, or threatening to boycott, Blue Shield of Massachusetts, Inc. The Antitrust Division of the United States Department of Justice has intensified the attack on physicians by bringing and threatening to bring criminal investigations and actions. Such criminal actions add criminal penalties—even incarceration—to the civil case risks of injunctive relief, treble damages, civil penalties and costs and expenses. In Boston and Atlanta, respectively, federal grand juries are already investigating allegations of criminal price fixing by allergists and obstetrician-gynecologist.

What are the antitrust laws? The antitrust laws are federal and state statutes, interpreted by courts and enforced by federal agencies (primarily the Department of Justice and the Federal Trade Commission) and state attorneys general, as well as by private litigants. The laws promote free competition by proscribing conduct which interferes with or hinders competition. The United States Supreme Court has described the principal federal antitrust law, the Sherman Act, as "a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions." It is the consumer whose interests the antitrust laws are designed to serve.

Until 1975, physicians, like most professionals, reasonably believed (if they thought about it at all) that the antitrust laws did not apply to them. They believed this despite the 1938 criminal antitrust case against the American Medical Association ("AMA") for boycotting a health maintenance organization. While federal officials now assert that the 1938 AMA case should have served as a "warning shot" there was little, if any, reason to expect antitrust scrutiny of physicians prior to 1975. In 1975, however, the United States Supreme Court made clear that the antitrust laws do apply to the professions.

Since 1975, the antitrust laws have been applied with increasing frequency to challenge physician conduct. Even during the Reagan years, when federal antitrust agencies' budgets were shrinking and there was a philosophical recoiling from antitrust areas which previously had been liberally expanded, the number of governmental and private antitrust actions against physicians soared. This apparent anomaly may be explained by the widely-held belief that enforcement of laws designed to promote free competition is the best way to control rapidly escalating health care cost, as well as by the fact that certain physicians at times have engaged in conduct which is agreed, even by conservative antitrust economists and lawyers, to have little redeeming competitive value. Some state attorneys general have found they can make political hay by pursuing well-publicized (and sometimes questionable) antitrust cases, supposedly to benefit "consumers" of their various states. Regardless of genesis, the recent increase in antitrust scrutiny has caused concern, confusion, unhappiness and expense to many physicians.

Physicians may encounter antitrust issues in myriad contexts. Antitrust issues may arise, for example, upon

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the denial, nonrenewal or restriction of a physician's or of a non-physician health care provider's hospital staff privileges. Antitrust issues may arise in the context of peer review. Antitrust issues arise where physicians or physician groups contract exclusively with a hospital or other health facility, where physicians establish or participate in joint ventures, and where physicians or physician groups merge. And, perhaps most notably, such issues arise in physician dealings with third-party payors.

It is this last context—physician dealings with third-party payors—which presents perhaps the most serious area of concern regarding potential antitrust liability. Classic antirust violations involve joint action taken by two or more competitors to limit or hinder competition, that is, so-called contracts, combinations or conspiracies "in restraint of trade." Such contracts, combinations or conspiracies are unlawful under the Sherman and Federal Trade Commission Acts and under most state antitrust statutes as well. It is impossible, hypothetically and without a full and detailed factual analysis of a specific case, to comment on the legality of any particulaar course of conduct. However, it is plain, particularly from recent government policy statements, speeches, investigations and court actions, that enforcement agencies, and many private litigants, will not hesitate to challenge as "price fixing" concerted or collusive action between or among competing physicians which directly or indirectly affects the price at which their services are offered. Moreover, concerted refusal by competing physicians to deal with a third-party in order to secure economic advantage might be challenged as an unlawful boycott.

The Department of Justice has warned against physicians' succumbing to the understandable urge to get together to discuss or gripe about their dealings with third-party payors, as, according to the Department of Justice, such discussions may easily turn into discussions of fee levels, presenting a "united front" of resistance, joint negotiations or other concerted action. The Department of Justice has warned that the joint action which is not part of a legitimate joint venture is fraught with danger, including serious criminal risk. It is imperative, whenever a physician contemplated any agreement or joint, cooperative or collective action with one or more competing physicians, to obtain the advice of an experienced antitrust attorney prior to taking any action. ■

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Annual Meeting of the Hampden District Medical Society

The annual meeting of the Hampden District Medical Society was held on April 11, 1989, at the Old Storrowtown Tavern in West Springfield. There were 101 members, spouses and invited guests in attendance.

At the Business Meeting Dr. Remsberg, our Treasurer, gave his annual report. A total income of $115, 168 and total expenditures of $114,980, left a balance of $180 in the black.

Dr. Gulab Shah gave the Auditor's Report and stated that the District Society was in good financial condition.

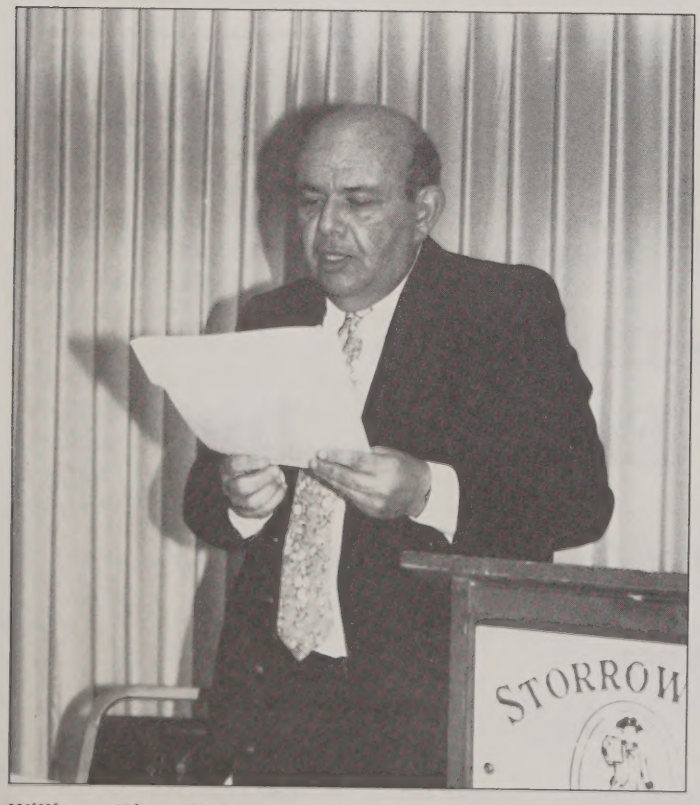
Chairman of the Nominating Committee, Dr. William Kiss, presented a slate of officers which was approved by the membership. The in-coming President is Nancy Weiss, M.D., the President Elect is Joseph P. Keenan, M.D. and Vice President Elect is Mark J. Mullan, M.D.

Dr. Cahil reported on the on-going saga of the Springfield 24. He reported that one person had settled with the Attorney General and four others may do the same. It is predicted that it may cost each person going to trial a half million dollars, approximately $90,000 has been raised in donations so far.

The social hour and dinner followed during which four members were honored for Fifty Years in Medicine. They were Haig Bozigian, M.D., Leopold Genest, M.D., James Lewis, M.D. and William Teahan, M.D. Present to accept the awards were Dr. and Mrs. William Teahan and Dr. James Lewis.

The speaker of the evening was Atty. Randolph Fenninger. Mr. Fenninger's talk was entitled Washington Update. Mr. Fenninger's past experience is that of an attorney, a lobbyist, and a government relations consultant. He is currently Senior Vice President of Mark Associates of Government Relations Consulting firm in Washington. He previously had spent nine years as a legislative attorney and lobbyist for the AMA and has had broad experience in working with our policies. He is currently working as a legislative consultant on major policy issues concerning payment for physicians under Medicare, NIH appropriations and regulations of clinical laboratories.

Mr. Fenninger gave a lobbyist's point of view of the many on-going studies of and attempts at redefining physician payment under Medicare. He covered much of the same material that Dr. Nelson had covered in the Winter Meeting. The final outcome of these studies of physician payment is still very much up in the air, but it would appear that some major decisions will be coming down by the fall. ■



William Kiss, M.D. presented nominating Committee Report.

Our New President, Nancy L. Weiss, M.D.

The following are two presentations made on April 7, 1989, to the Special Commission to Study Physician Shortages which we think are worth sharing with you.

The Editors

Report by Philip Stoddard, M.D.

Ladies and Gentlemen:

Thank you for the opportunity to share some of my thoughts with you today. My presentation will be divided into 6 categories.

I. A brief CV
II. Summary of a study that caused me to alter my practice.
III. My consideration of further altering my practice
IV. Springfield area statistics regarding physicians
V. Physician apprehension
VI. My concerns

I. I am Philip Stoddard, age 52. I am in solo practice in Plastic and Reconstructive Surgery in Springfield. I started practice at age 36 after 10 years postgraduate training finishing my General Surgery at the Beth Israel Hospital in Boston.

I am Board Certified in two specialities, General Surgery and Plastic Reconstructive Surgery.

I am past President of the Hampden District Medical Society, currently Executive Councilor to the Mass Medical Society and sit on its Executive Board, and I am President of the Mass Society of Plastic Surgery.

II. In 1986 I conducted a study of all the closed claims against plastic surgeons from 1975 to 1985. As a result of that survey I *altered* my practice *to lower my risk exposure.* I no longer do cosmetic nor hand surgery, thus reducing my risk exposure by 90% of the monies paid out according to that survey.

However, for the past 2 years I have been unable to reduce my risk relativity as I have been ping-ponged back and forth between the JUA and the Insurance Commissioner's Office. Neither office is willing to grant me a lower relativity premium even though my risk has been reduced.

III. I'm considering further altering my practice by reducing or stopping the care of cancer patients. The reason for this is that there is a lack of X-ray technicians, X-ray therapists, and radiotherapy units in the western part of the state to take care of my patients. Typically, they have to *wait 6 to 8 weeks* before they can begin therapy. Even at that, they must be shipped off to Hartford, Northampton, or Worcester in order to receive care. This is an unconscionable delay in treatment for these unfortunate patients.

IV. From 1985 through 1987 the Springfield area lost 70 physicians of the 500 practicing physicians, to *early* retirement, or to moving out of state. In the last 3 days I have learned of three physicians leaving the state—One General Surgeon to West Virginia, an Anesthesiologist to California, and a Thoracic Surgeon to California. That is a lot of expertise no longer available to the Springfield area.

V. Do you know of an upbeat physician? All physicians in Massachusetts are discouraged and depressed.

Why? Because of legislative restraints with which you are familiar.
Why? Because of a surly Board of Registration.
Why? Because your Attorney General is suing 24 Springfield Obstetricians for resigning from Blue Shield.
Why? Because of a malpractice climate that is driving us crazy.

1. Expectations of normalcy.
2. Multimillion dollar awards with no restraints by the judges.
3. Retroactive premiums—what other business works that way?
4. And you wonder why ⅓ of the health care dollar is spent on defensive medicine?

VI. I'm concerned that access to medical care in Massachusetts will be rationed. If the practice of medicine is made so difficult and so onerous it will be difficult to recruit people to come and fewer and fewer to stay. Already across the country Massachusetts is considered the Beirut of Medicine. This is reflected in general also by application to medical schools having dropped from 15 at the time for each spot when I applied to medical school to 1.5 at the present time. Incidently, I'm considering moving. Sunday night I returned from looking at a practice opportunity in North Carolina.

Thank you for permitting me to express my concerns with you.

continued

Report by Ms. Judith Schumacher continued

My name is Judith Schumacher and I am responsible for Planning and Marketing at The Cooley Dickinson Hospital in Northampton. Prior to joining Cooley Dickinson I was Director of Planning and Marketing at Noble Hospital in Westfield. In both positions a large portion of my time has been focused on medical staff development planning and physician recruitment.

At Noble Hospital, given the size and make-up of the medical staff, recruiting was a high priority issue. But even with significant time and attention being spent on physician recuritment, it still took four years to recruit an obstetrician to Westfield, when there was no full time OB/GYN coverage in the town and the hospital has been working for over five years to recruit an orthopedist without success. During this same period, I saw physicians leave Massachusetts to practice elsewhere, motivated only by the negative practice environment in Massachusetts. Included in this group were neurosurgeons, anesthesiologists, primary care physicians, and obstetricians. Those who joined the medical staff came to Massachusetts for almost exclusively personal reasons-family, spouse's professional opportunity, and so on.

In the Cooley Dickinson service area, access to physicians is a major issue. Many towns are significantly under served by physicians with towns such as Amherst having virtually no physician in private practice serving the population.

During 1988, Cooley Dickinson commissioned a comprehensive study to determine the specific physician needs for its service area. To determine the actual number of needed physicians, the study used as its base the findings of the Graduate Medical Education National Advisory Committee (GMENAC). GMENAC was established in the late 1970s under the auspices of the Department of Health and Human Services at a time when concern was growing about the potential surplus of physicians.

Comparing the standard developed by GMENAC to the 1990 projected population of approximately 104,000 in Cooley Dickinson's primary service area, a net need was found of 89 physicians in all specialties—including 29 primary care, 10 medical specialists, and 8 in the surgical specialties. If the recommended number of physicians was compared to Cooley Dickinson's medical staff members under 60-total need then grew to 98 physicians including 34 primary care physicians, 10 in the medical subspecialties and 9 in the surgical subspecialties.

We have recently established a committee of physicians to develop a detailed physician recruitment strategy and action plan to recruit aggressively these needed physicians.

Recruiting anywhere near that number of physicians in this environment is almost impossible.

In attempts to recruit physicians either to remain in or come to Massachusetts, the most frequent reasons for a refusal even to consider the available opportunity include:

1. malpractice
2. reimbursement
3. the Board of Registration in Medicine
4. the fiscal crisis of Massachusetts hospitals

Perhaps more damaging than the specifics of any of the above is the perception that in addition to being over-regulated, the management of regulatory and economic issues appears to be very arbitrary.

The combination of all of these factors makes Massachusetts an undesirable place for physicians to establish their practices.

Quality of life is a major issue for most physicians across the country.

When an individual selects medicine as his or her career, he or she also accepts a work life, level of stress and a kind of personal responsibility that most of us never have to deal with. Given the lifestyle issues with which all physicians must deal, to add to these additional, and perhaps unnecessary, regulatory and financial disincentives, is not in the best interest of residents of the Commonwealth.

The intent of an oversight function such as the Board of Registration of Medicine is not bad. The desire to provide optimal access to medical care by encouraging physicians to accept Medicaid is not bad. And the goal of keeping patients' medical costs down which is the goal of the ban on balance billing is not bad.

However, we have reached the point where the existing approaches to these issues are working to the disadvantage of those very individuals whom the State is trying to help.

The physicians who are leaving the State aren't suffering. The physicians who stop their participation in various plans aren't suffering. It is the residents of Massachusetts who are suffering because they are finding, and will continue to find, that their access to necessary health care services, as provided by private practitioners, health maintenance organizations, and hospital-based programs, is significantly reduced.

Thank you. ■

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Obesity Is All In The Mind

*Observations on Obesity by the Creator of the Pro*Health Program at the Osborn Clinic, William A. Anderson.*

When several physician friends and acquaintances suggested that I write an article for the Hippocrat about the Pro*Health Program, I wasn't sure what the Hippocrat was. I soon found out, and so, with the encouragement of Drs. Fred Schwendenmann, Peter Kelly, Ronald Sorenson and Martin Broder, I offer you the following.

If you are not familiar with the Pro*Health program, a definition is in order. This program is a structured system of training and counseling for anyone who is overweight, who is sincerely interested in solving the problem. It is psychologically or behaviorally oriented, and addresses the multiple issues that need to be considered and attended to if one is to find a real solution to their "weight problem." Its goal is the permanent alteration of the personality and behavioral factors that lead to obesity, and hence, attainment and maintenance of healthy lifestyle behaviors and healthy body weight.

In the Springfield area, The Osborn Clinic, in Agawam, offers this program. The Osborn Clinic is a full service counseling center, offering a wide range of mental health services, with a staff of over thirty psychologists, counselors, and consulting psychiatrists. Dr. William Osborn is the Clinical Director and would be happy to personally respond to any questions you may have about the program or any other clinical services.

The primary point that I'd like to make in this article is that obesity (or any degree of overweight), in almost all cases, is not a physician problem or disorder. It is a *behavioral or psychological or emotional problem with a physical result.* This physical result creates many other problems, some of which can be medically treated, all of which would be improved by the removal of the excess weight. However, first and foremost, overweight is a behavioral and psychological disorder.

Thank God for physicians—you healers who treat our physical disease and disorders that we present to you. It is the lifestyle and habits of our culture that give birth to many of our disease states. It is the way that our society has learned to think, believe, act and behave that makes most of our sickness. And without a change in these beliefs, attitudes, habits and lifestyle behaviors, physicians are presented with an ever increasing procession of tragic cases to treat, and *demands* to be healed, whether or not the physician is treated fairly.

In the same way, obesity is a creation of the lifestyle, habits, beliefs and attitudes of your patient. Without a real change in these behavioral and cognitive patterns, your patient is destined to present you with a continuing litany of symptoms of ill health and disease. A diet, surgical approach, drug therapy, modified fast, or simplistic behavior modification program may produce a short term alteration of your patient's body. But only a deeper change in the fabric of the patient's lifestyle or personality will result in the permanent physical and behavioral change that is needed to solve the problem by attacking the root or cause.

Briefly, I'd like to discuss several of the critical aspects of the problem and how the Pro*Health approach addresses these issues.

No one is born with the attitudes, beliefs, habits and lifestyle behaviors that cause them to be overweight. These things are learned and acquired, and once learned by the human mind, are extraordinarily difficult to unlearn.

As we live and grow, we develop firmly rooted beliefs, such as our self concept, images of who we are and what we will be, and the roles that food plays in our lives. Some of us believe the "you're just like your mom (or dad)", or that "you're getting middle aged spread",

continued

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Obesity Is All In The Mind

continued

and these beliefs and images work on an unconscious basis, as if someone had planted hypnotic suggestions in us. Some of these beliefs and feelings about food, the supper table, and bedtime snacks are so powerful that changing them is akin to giving up family, or losing meaning and spiritual support in life.

We often tend to think that changing these attitudes and feelings is the result of "will" and intellect-that if a person got the facts and were made of the "right stuff" that they would simply change. But then we are confronted with the fact that many of us (patients, colleagues, and even ourselves) who are bright, knowledgeable, and possessed of a high degree of "character", are caught up in a lifestyle that may include smoking, overconsumption, lack of exercise, abuse of alcohol and other intoxicants, or other self-destructive activities, such as compulsive gambling or spending.

It is believed that we are born with certain physical, psychological, and emotional needs, such as our needs for food, shelter, freedom from pain, security, society, and love. But no one is born with a need for 150% of their body's caloric requirement.

Some of us learn to satisfy our needs for relief of stress, comforting, companionship, and even purpose or spiritually in inappropriate ways. We may either condition ourselves (like Pavlov's dog) to satisfy these needs *while* we eat, or we may use eating as a *substitute* for the satisfaction of these needs.

Again, it is natural to assume that people are in control of the choices and actions that they make, day in and day out. But that is true in only some of the cases, some of the time. Most of us are at the mercy of our habits, some of them so deeply learned, and so contributary to our mistaken sense of well-being that we go to the grave with them. We become slaves to our habits and addictions, regardless of our intellect, scientific knowledge, good character and basic decency.

To succeed at permanently changing our habits and the underlying motivating factors, we must deal with the powerful reality of the unconscious programming that motivates our habitual andd compulsive behaviour and thought patterns.

Even with simple habit, where the learned behavior is not complicated by its connection with important psychological needs, change cannot occur easily without effective technique based upon an understanding of the dynamics of behaviour formation.

The Pro*Health Program at the Osborn Clinic is a comprehensive approach to a complex problem. Psychologists describe it as an eclectic approach, combining theory and technique from psychodynamic, behavioral, cognitive, and humanistic psychology.

Your patients are led through an educational process that brings them to a high degree of self-knowledge regarding their own psychology and behavior, as well as nutrition and the role of exercise in their total well being. More importantly, they engage in a process of therapy and practice of technique that enables them to experience changes, "reprogramming" if you will, in the habits, attitudes, thoughts and behaviors that shape their life and their bodies.

Clients are exposed to 11 one-hour teaching sessions over a three month period, and, among other things, learn the origins of their habits and beliefs, techniques with which to change them, valuable stress reduction and relaxation techniques, and psychological concepts and techniques that help them to become more self-loving and self-nurturing, promoting their own highest health potential. These sessions are provided on audio tape, and spaced repetition is used to enhance internalization of the materials.

At the same time, they meet with a clinic therapist in a private session on a regular basis. The formation of this relationship is very important in developing the effective application of the techniques learned from the program, and in confronting and satisfactorily dealing with the critical issues encountered.

The actual nutrient regimen is a reduce calorie regimen of the patient's own creation, women consuming 800-1000 c./day avg., and men, 1000-1300 c./day avg. This is, of course, during the reducing portion of the program, maintenance being approximately double. I want to add here that in the course of the training, most clients become extremely motivated and eat high quality nutrients, as well as exercise, and tend to make good selections based upon nutrient quality as well as personal taste, as they become educated in nutrition facts.

One of the results of the psychological training is for the clients to take full personal responsibility for their own conditions and **causing** their **desired** conditions. We teach a preventive approach to medicine, and the client is led to consult with his or her physician in regards to weight loss, and to get regular physical examinations.

This approach is centered on patient well-being and total health rather than weight loss. It focuses on the development of a mind set and lifestyle that creates health, with proper body weight being one of those factors. Please forgive us, though, if we seem to focus on "Losing Weight", because that is usually what clients are interested in. In fact, they usually get scared when we tell them they have to change. They'd rather take a pill, or a drink, or go in for surgery and have you fix things for them. They often dream of just going to sleep, and waking up cured.

But it won't work that way, because it is not that kind of a problem. Obesity, overeating and other eating disorders are problems that are primarily in the mind.■

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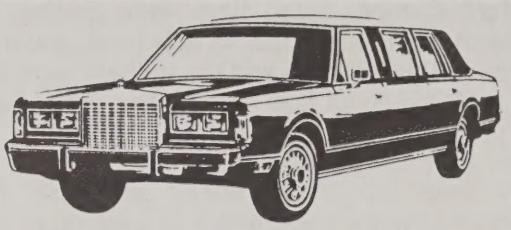

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The Cynic Bulletin

The Premier of the Soviet Union woke up with a pounding headache. Despite glasnost and peristroika, free elections and relaxed religious restrictions, despite withdrawing troops from Afghanastan and cutting back forces in Eastern Europe, bread lines were getting longer, nationalism continued to rear its ugly head, and the older members of the Politburo and the military were starting to wax nostalgic about how much better things had been in the good old days.

It was time for another trip!

Every time things got sticky at home, Michael Gorbachev had made a pilgrimage to some other country, confounding his enemies, creating international good will, and best of all, quieting his critics on the home front. That still played well with the people.

But where to, this time? Should he go to a rich capitalist country and make a dramatic speech reducing arms even further? Should he visit a third-world country and point out that the Soviet Union had no more interest in interfering with the political evolution of other countries? Or should he visit a brother socialist country and preach peristroika and glasnost?

After some thought, he decided on the last.

There wasn't much sense in going to an Eastern European country. Most of them had already kicked over the traces and even though he could expect parades and cheering crowds he would just raise the envy level back at home. And those dirty little thrid world communist states were gray, unpleasant, and usually hot and dirty. And then there were countries like Albania, North Korea, and China, all of whom would probably see to it that his plane accidently blew up as it landed on the runway.

Why didn't he think of it sooner? A stroke of genius! He would visit one of the most repressive left wing dictatorships in the world, the Commonwealth of Massachusetts!

Snavely S. Reptile, famous malpractice attorney at law, was selected to guide the Premier on his tour through the Bay State. Reptile was uniquely qualified, having an intimate knowledge of the byzantine legal system under which the Commonwealth operated; in addition, Reptile was a personal friend of every individual with any power at all in the state.

The day finally came. Gorbachev stepped off the Aeroflot jetliner onto the runway of Logan Airport, having had to circle for only two hours. He was escorted into Reptile's stunning limosine, which was fortunate, since the vehicle got stuck in traffic, and had it not been for the air conditioning, the wet bar, and the color television, Gorbachev may have had a seizure. "In Soviet Union," he comments, "we have no traffic problem." We only have 72 cars in all of Moscow!"

"We envy you, Michael," replied Reptile. "The Governor is doing something about that right now. We are going to raise auto insurance to ruinous levels and bill premium surcharges retroactively. That way, only the very wealthy will be able ot afford a car."

At the hotel, Gorbachev had to step over an unconcious alcholic, "In Soviet Union," he commented, "alcohol is bad problem also."

"Here, too," replied Reptile. "But we are trying to get some new taxes put on alcoholic beverages, which should make it unaffordable except to the very wealthy."

"Is how you run state?" asked the Premier. "Just tax until problem goes away?"

"Partly," replied Reptile. "But we have some other tricks. For example, as you relax things in the Soviet Union, everyone is trying to emigrate, right?"

"Is correct," said the Premier, sadly. "Rooshian peoples spend all time trying to find relatives to visit in other countries. Patriotism is dead."

"Well," replied Reptile, "We think we have an answer. For a while we were seeing physicians and other high-income groups leaving the state in droves. We then passed a law that permitted insurance companies to charge additional money for malpractice premiums which had been issued in years gone by. And we made it a law that any physician leaving the state or retiring had to have paid in full malpractice insurance for several years afterwards. We call it a "tail". It's slowed physician emigration to a trickle."

"Is brilliant," replied Gorbachev. "And if it works for physicians, you will do it with other groups, yes?"

"Of course," replied Reptile. "And the beauty of it is that if you work on just one group at a time, they never get enough power together to do anything to stop you."

"Ah, yes," said the Chairman of the Communist Party. "I know democracy is a sham, which is why I started it in Soviet Union. As Lenin said in secret document, 'Democracy is opiate of people.' But don't you worry even a little that one of these days there will be rebellion and your government turned over to (gasp) Republicans?"

Gorbachev and Reptile both spat vigorously and rinsed their mouths with a swallow of Jack Daniels. The Word, after all, was poison in both the Soviet Union and Massachusetts.

"We think we have an answer to that, too," replied Reptile. "We are trying it out on physicians as well. The idea is to have the Attorney General prosecute any group of individuals who act to protest something we feel is in the best interest of the Party. Let me tell you about conspiracy law and the Springfield 24."

Gorbachev listened with amazement. Here was a government which was repressive beyond the wildest dreams of Stalin, and yet managed to mask all of this from public view behind a facade of democracy and liberalism.

That night as Gorbachev took his leave from Reptile and his wife, Myrtle, he could hardly wait for his summit concert with—who was it again, that short fellow with the bushy black eyebrows and the funny last name? Yes, that was it Comissar Dukakis! ■

Excerpts of MMS Executive Briefs

MMS Upheld on Insurance Challenge

Earlier this week, the state's *Supreme Judicial Court* upheld a Society challenge to a ruling on computation of the Joint Underwriting Association's (JUA) individual deferred premium liability (IDPL) credit. The Society had challenged the Insurance Commissioner's 1988 ruling on this subject. The IDPL is paid by physicians who stop practicing medicine or leave the JUA for reasons other than death, retirement (due to disability or after age 65), or relocation outside the state after completion of residency/internship. The credit applied against the IDPL reflects payments made by physicians for their annual, proportionate share of the total DPL.

The Society had appealed the issue of whether the credit should be reduced by amounts attributable to exemptions from DPL payments, and attributable to bad debts (so-called 'subsidies'). *Kevin Griffin,* an attorney with the Society's legal counsel of Rich, May, Bilodeau and Flaherty, argued for the Society that (1) the existence and amount of the IDPL credit were unambiguous as established in the statutory language and (2) the Insurance Commissioner did not have the discretion to adjust the IDPL credit amount.

No-Fault to be Reconsidered

In a reversal of its April 26 vote, the legislature's *Joint Committee on Insurance* agreed to reconsider the Society's "no-fault" bill to reform the medical malpractice system. The Committee voted on May 2 to extend discussion for the bill, and is expected to vote a second time on the future of no-fault before the end of this legislative session. Also on May 2, over vigorous opposition from Blue Cross/Blue Shield, the Committee gave the Society's *unit system* bill a favorable report. The bill now goes to the House for further action. The unit system bill would not allow Blue Cross/Blue Shield to make up an operating deficit by not reimbursing physicians; the Committee agreed with the Society that physicians should not be liable for any Blues' deficit.

Also on Beacon Hill, Massachusetts hospitals are still unable to obtain any fiscal relief from the legislature. After the House voted in April to put the $50 million shortfall funding back in the Fiscal Year 1990 budget, the House leadership forced a second vote and the funding was removed. The hospital industry tried again this past week, when the House began deliberations on a supplemental budget for Fiscal Year 1989—and again, hospital funding was added and subsequently removed from the budget. The state's growing revenue deficit and the House's entrenched "no new taxes" philosophy are setting the stage for a bitter legislative fight on the budget in the coming months.

No-Fault Testimony Heard

Calling the present medical malpractice system "unfair, unworkable," and one that "doesn't help patients as it was intended to," *"MMS Vice President Barry M. Manuel, M.D.,* called on the legislature's Joint Committee on Insurance to favorably report on H 1773, the Society's "no-fault" bill. Dr. Manuel led off MMS testimony at the April 12 hearing devoted exclusively to "no-fault." In his testimony, Dr. Manuel cited the 550 percent in malpractice premiums since 1981 as a major reason for the present negative practice climate in Massachusetts and the shortages of physicians in various specialties and areas. Also testifying in support of the bill were *W. Hardy Hendren, M.D.,* chief of surgery at Children's Hospital and currently president of the Massachusetts chapter, American College of Surgeons.

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Excerpts of MMS Executive Briefs

continued

He described the physician shortages at his facility and asked the committee to "do something progressive and innovative" to solve the medical malpractice problem.

Also testifying in favor of no-fault were *Michael Stelluto, M.D.*, President of the Mass. Chapter, American College of Obstetricians and Gynecologist; *Brian Golden, M.D.*, president of the Massachusetts Orthopedic Association; *Stephen Friedberg*, chief of neurosurgery at the Lahey Clinic; *Brian Shaw, M.D.*, an orthopedic resident at Mass General; and *Eugene Leibowitz, M.D.*, a Pittsfield neurosurgeon. *John Parsons, M.D.*, a general-vascular surgeon at Northampton's Cooley Dickinson Hospital, and *James Lyons*, president of Cape Cod Hospital, gave the Insurance Committee information on physicians shortages at their facilities also provided to the Special Commission on Physician Shortages.

Predictable opposition to "no-fault" was heard from the state bar association and the trial attorney's bar, as well as Mass. PIRG. Attorneys called "no-fault" a system under which "no physician will ever again pay malpractice insurance—the taxpayers will pay instead," and noted "there should be a high burden on the supporters of no-fault to prove that medicine would be better, and Massachusetts a better place to practice" with such a system. A vote by the Insurance Committee on the bill is expected within the next few weeks.

St. Paul's response to *NIGHTLINE* Study.

The Society recently received a response from the St. Paul Companies concerning the MMS *Executive Brief's* March 3 story, *Nightline Investigates Malpractice Insurers.* The story described a February 14 ABC *Nightline* program on a Minnesota study of medical malpractice insurers. The Minnesota Commerce Commission, which conducted the study, examined medical malpractice insurance claims for 1982-87 involving the Minnesota Medical Insurance Exchange and the St. Paul companies; the Commission reported it could not find justification for the 300 percent increase in premiums to physicians. As a courtesy, this week's *Executive Brief* includes the following response from St. Paul's to the study:

"The Massachusetts Medical Society recently published information regarding the Minnesota Department of Commerce's Medical Malpractice Claim Study, 1982-1987.

St. Paul Fire and Marine Insurance's disagreement with the conclusions of the report is based on a number of problems with the methodology used by the department. For example, the study failed to acknowledge that the biggest, toughest and most costly medical liability claims in the data remain open and are not reflected in the report's conclusion. The fact is that claim payments have risen substantially—easily proven by looking at actual payments made—and premiums charged mirror those costs.

In conclusion, we cite the assessment of one of the nation's most respected actuarial firms, Tillinghast, which serves as a consultant to both state insurance regulators and insurance companies: 'The report used unsound procedures and inappropriate data in evaluating the reserve adequacy and rate levels and the conclusions reached are incorrect.' " ■

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Committee Activities

This has been a busy time of year for HDMS committees.

At the March 21, 1989 meeting of the Executive Committee the finances of the Hampden Hippocrat were discussed along with its change in advertising policy. Though the April/May edition still was expected to be in the red, Ms. Barnes predicted that the June/July issue would have sufficient advertising income to pay for itself. Criteria for accepting ads in the Hampden Hippocrat was also discussed.

The problem of attendance at Mass. Medical Society Council Meetings had been brought up by Dr. O'Connor, President of the Mass. Medical Society. Dr. Brigid Glackin felt she wished to address this issue and asked to meet with Dr. O'Connor to discuss the problem.

Plans for the up-coming April meeting were discussed.

The Executive Committee met again on April 18, 1989. This being the final meeting under Dr. Rich's reign. The highlights of this meeting were a report on the Commission Shortages Hearing held on April 7, 1989. (Please see presentations of Dr. Stoddard and Ms. Schumacher of Cooley Dickinson Hospital printed elsewhere in this issue.) It was disturbing that representatives of the Baystate Medical Center and Medical West apparently told the commission that they did not have problems recruiting physicians.

Dr. William Baker, our Nominating Councilor, had been invited to the meeting by Dr. Rich to explain how the Mass. Medical Society's Nominating Committee works. Dr. Baker said that the committee holds a meeting at the Fall Council Meeting at which potential slots that are open both for officers of the state society and Delegates of the American Medical Association are discussed. He went on to say: "In the recent past, Hampden District has had two full delegates to the American Medical Association's House of Delegates. Dr. John Ayres and Dr. Gus Siragusa will no longer be Delegates. Dr. Siragusa has already moved out of state and Dr. Ayres will attend his last Council meeting in December, 1989. Dr. Greg Slachta is at present an Alternate Delegate from Mass. Medical Society, but he has said he will accept a full Delegate's slot from the Mass. Urological Association. For the first time in some years, Hampden District will not have a representative in the Mass. Medical Society's AMA Delegation."

Dr. Baker asked to have the names of any persons who might be interested in the future in holding a position on the Delegation to the AMA. Dr. Baker said each person who is interested will be asked to submit his or her resume to Dr. Baker in December. Dr. Baker will forward this resume to the Nominating Committee and the Committee will invite each person to meet with them in January for an interview before the Committee. At the February Council Meeting a recommendation from the Nominating Committee is made to the entire Mass. Medical Society Council. Dr. Baker said the full AMA Delegate slot should be held by persons who have worked within the association system for some time. However, he felt that the Alternate Delegate slot would give a new Council member the means to attend the AMA Meetings and "learn the ropes". Dr. Baker said Dr. Michael Collins will be proposed as a Delegate. He said Residents and Students have 2,200 members at Mass. Medical Society and have asked for more representation at the AMA House of Delegates Meetings. Therefore, this year a Resident will be an Alternate Delegate. Dr. Baker again asked for the names of any HDMS members who might be interested in the AMA House of Delegates be sent to him.

The final issue discussed was Dr. Rich feeling that the present location of the Medical Society office was not satisfactory. He set up an Ad Hoc Building Committee to consist of himself, Dr. Remsberg, and Dr. Weiss to discuss relocating the HDMS office to a more accessible location.

The Medical Religious Committee met on March 31, 1989, under the chairmanship of Dr. James Fitzpatrick. The topics for discussion for their annual program which is planned for October were discussed. Among the topics presented were Nursing Care of Aids Patients, Ethics of Treating Mental Illness and Physicians Can Help Patients To Die. Dr. Remsberg had reported that he had attended a seminar on legal and ethical considerations in physician risk management and thought that the main speaker, Rev. Matthew Temple of Nazareth College in Rochester, had given an excellent presentation. After much discussion it was decided that Dr. Fitzpatrick would contact Rev. Temple to see if he would be interested in being a speaker. The Committee will meet again on May 12, 1989.

The Public Health Committee has been very active, meeting in both March and April. Their main topic of discussion has been drug abuse and there is a report elsewhere in this issue on that matter.

Finally the Membership Committee under the Chairmanship of Dr. Robert Chircop met on March 15, 1989, to discuss methods of recruitment. Plans for a second phon-a-thon to be held on May 3 from 7:00 to 9:00 were made. There was also some discussion centered on senior membership requirements and a by-law change regarding senior membership was being considered. ■

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Welcome New Members

Patrick M. Cooke, M.D.
299 Carew Street
Springfield, MA 01104

BORN	August 7, 1953
PREMED:	SUNY at Cobleskill, New York 1973-75 Howard University, Washington, D.C. 1976-79
MEDICAL:	Howard University 1980-84
INTERNSHIP:	Baystate Medical Center 1984-85
RESIDENCY	Baystate Medical Center 1985-87
FELLOWSHIP:	Brown University, Rhode Island 1987-6/89
SPECIALTY:	Internal Medicine/Gastroenterology

Alan M. Harvey, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN:	January 24, 1953
PREMED:	Middlebury College, Vermont 1970-74
MEDICAL:	University of Alabama 1979
INTERNSHIP:	University Hospital, Alabama 1980-81
RESIDENCY:	Hartford Hospital, Connecticut 1981-83
FELLOWSHIP:	Yale University 1987
SPECIALITY:	Anesthesiology

Margaret S. Kranyak, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN:	October 14, 1953
PREMED:	University of Cincinnati 1975-79
MEDICAL:	University of Cincinnati 1980-84
INTERNSHIP:	University of Virginia Hospital 1984-85
RESIDENCY:	University of Virginia Hospital 1985-88 Department of Radiation Oncology
SPECIALTY:	Radiology/Radiation Oncology

Alan A. Lareau, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN:	January 2, 1958
PREMED:	St. Michael's College 1976-80
MEDICAL:	University of Connecticut 1984-88
INTERNSHIP	Baystate Medical Center 1988-6/89
RESIDENCY:	Baystate Medical Center 7/89-1991
RESIDENT:	

continued

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Welcome New Members

continued from previous page

Samir A. Mujalli, M.D.
444 Montgomery Street
Chicopee, MA 01020

BORN: November 18, 1943
PREMED: Terra Sancta College, Jordan 1958-62
MEDICAL: AIN-SHAMS University, Cairo, Egypt 1962-69
INTERNSHIP: New Britain General Hospital 1972-73
RESIDENCY: A.C. Logan Memorial Hospital, New York 1973-76
Nassau County Medical Center, New York 1977-79
FELLOWSHIP: Nassau Hospital 1979-80
SPECIALTY: General Surgery

Sarah Ryterband, M.D.
333 East Columbus Avenue
Springfield, MA 01105

BORN: June 30, 1951
PREMED: Lawrence University, Wisconsin 1968-72
Wright State University, Ohio 1973-75
MEDICAL: University of Cincinnati College of Medicine 1976-80
INTERNSHIP: The Memorial Hospital, Rhode Island 1980-81
RESIDENCY: Pawtucket, Rhode Island 1981-83
News Brunswick, New Jersey 1985-87
FELLOWSHIP: Burlington, Vermont 1987-88
SPECIALITY: Anesthesiology/Family Practice

Steven Steiner, M.D.
Wing Memorial Hospital
Wright Street
Palmer, MA 01069

BORN: August 21, 1947
PREMED: City College of New York 1964-68
MEDICAL: New York Medical College 1968-72
INTERNSHIP: Montefiore Hospital 1972-73
RESIDENCY: Montefiore Hospital 1972-76
SPECIALTY: General Surgery

Howard E. Silverberg, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: March 3, 1962
PREMED: Cornell University 1980-84
MEDICAL: University of Vermont College of Medicine 1984-88
INTERNSHIP: Baystate Medical Center 1988-6/89
RESIDENCY: Baystate Medical Center 7/89
RESIDENT:

Peter S. Greene, M.D.
2 Main Street
Monson, MA 01057

BORN: April 18, 1949
PREMED: Columbia College, New York 1967-71
Columbia University School of General Studies 1972-74
MEDICAL: College of Human Medicine, Michigan State University 1974-78
INTERNSHIP: University of Massachusetts 1978-79
RESIDENCY: University of Massachusetts 1979-81
SPECIALITY: Internal Medicine

Gerald E. Moody, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: February 9, 1956
PREMED: University of Southern Florida 1974-77
Georgia State University 1979-81
MEDICAL: Medical College of Georgia 1983-87.
INTERNSHIP: Baystate Medical Center 1987-88
RESIDENCY: Baystate Medical Center 1988-present
SPECIALTY: Anesthesiology
RESIDENT:

Steven M. Samuels, M.D.
305 Bicentennial Highway
Springfield, MA 01118

BORN: November 25, 1952
PREMED: Oberlin College, Ohio 1970-74
MEDICAL: University of Louvain, Belgium 1974-80
INTERNSHIP: St. Agnes Hospital, Maryland 1980-81
RESIDENCY: St. Agnes Hospital, Maryland 1981-83
FELLOWSHIP: University of Cincinnati School of Medicine 1983-85
SPECIALTY: Internal Medicine/Gastroenterology

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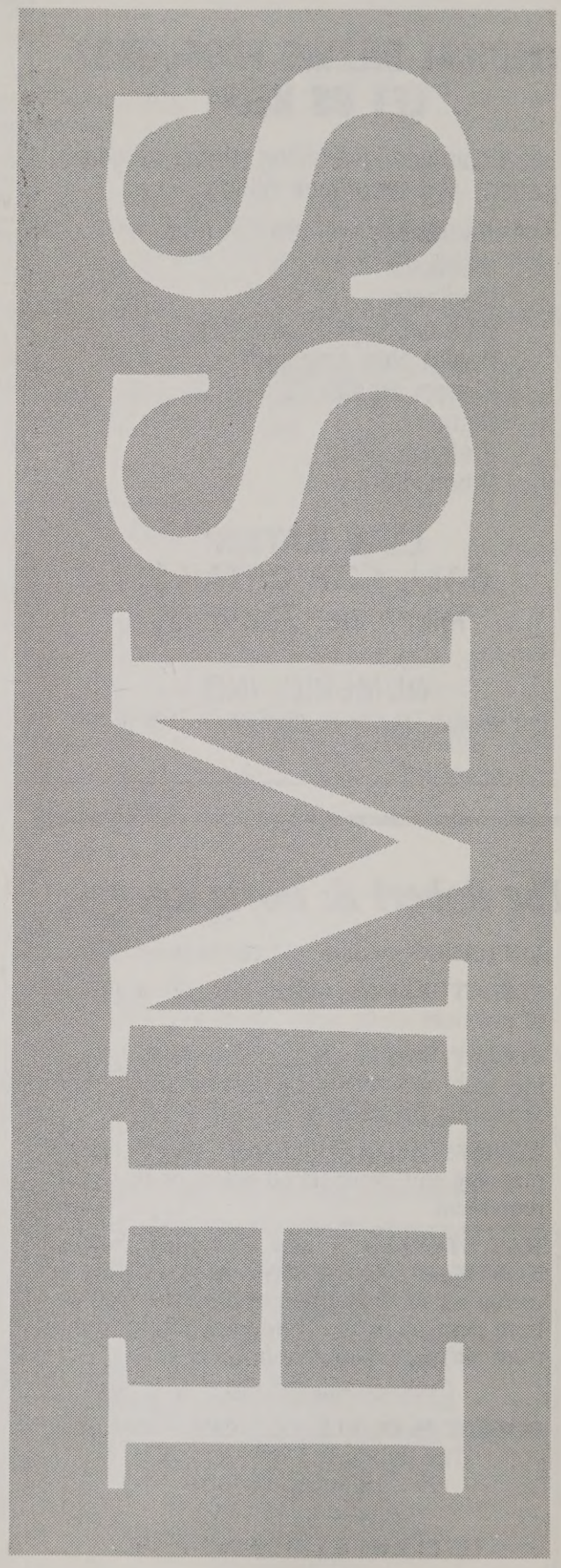

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